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LETTERS

Our Farflung Correspondents

The following letter was written to Dr. J. Howard Means, '11, by Dr. Isaac M. Taylor, '45, who is serving as medical officer on Operation "Deep Freeze Antarctica."

Dear Dr. Means:

Your Christmas card and your letter reached me today. How delightful to hear from you. Our last mail leaves New Zealand on 15 January, so you won't have the opportunity to answer this until next September but I shall hope to hear from you then.

I can't begin to tell you what a marvellous and exciting time I'm having—the trip is turning out to be as good as I could possibly have hoped—better even. We had a delightful time, three days in New Zealand and then had an eight day passage to the ice. We've been here at Hut Point for ten days in an advance camp, and now the camp ships are being escorted in by the ice breakers to a point close enough to unload material and supplies for flying and for our winter base.

Hut Point is the site of Captain Robert F. Scott's winter camp for two years in the 1901-03 expedition. You will find good descriptions of it in Scott's "The Voyage of the Discovery." The older editions have good photographs of the area. I don't think Scott gives an adequate picture of the natural beauty of this place, and I'm sure I can't. We are on the west side of Ross Island looking south and west across McMurdo Sound at the mountains of the mainland 30 miles away. These are gorgeous and dramatic peaks rising to 15,000 feet, covered with snow. The Sound between is still frozen hard with the winter's ice. Our weather has been good except for two days of blizzard, and of course, the sun is up twenty-four hours each day. Unusual beauty accompanies the illumination of the land from each of the 360° of the sun's course. The air temperature does not get above freezing, but the snow is melting under the constant sun. Behind the camp are low basalt hills which make excellent hiking areas for one like myself unaccustomed to walking.

Captain Scott's cabin still stands in good condition after 54 years. It's filled with snow and ice and we hope to excavate it and restore it as a memorial. On one hill nearby stands the memorial cross to Scott, erected in 1913 after his body was found, and on another a cross to Seaman Vince, who died in Scott's first year here in 1902. Schackleton spent the winter here in 1908, and I don't believe many people have been ashore since. The reminders of the English are everywhere about us.

Every day is a new adventure, and I live in constant anticipation or excitement or appreciation of nature. I suppose things will be duller thru the winter night, but even then there will be absorbing things to see and learn and do. Medically we are operating at a very primitive level in this base camp, but the ships are available for any serious problems, and I will be well equipped when the winter base is built.

ISAAC TAYLOR, '45

Department of Amplification

In the January issue of the Bulletin *the report on the Dunham Lectures misspelled the name of Dr. Otto Krayer on several occasions. Dr. Krayer graciously accepted our shame-faced apology. We continue, however, to wince under the lash of others like the author of the following letter.*

To the Editor of the *Bulletin:*

The last issue of the *Bulletin* was such an interesting one that I am stimulated to express my appreciation. An additional stimulus is the report on the Dunham Lectures. It was valuable to read about Dr. Winterstein, and particularly useful to note Dr. Crier's remarks. The brief account of the Lectureship might have included some additional historical material. I assume that the usual limitations of space and time prevailed and so take the liberty of adding to the Committee background of Dr. Winterstein's lecture. Last year's Dunham Lectureship Committee was chaired by Dr. Crier; also serving on the Committee were Deans Bury and Greep (sic), and Drs. Orb, Villey, Sohlmun, Muhnsin, Landiss and Thaugheron. The important role of each of these gentlemen in the functioning of the Harvard Medical and Dental Schools leads me to mention them specifically. I should have liked to continue my investigation to include the members of the committees of other years but a publisher's deadline interfered, hence this preliminary note. Incidentally, I hope the staff of the *Bulletin* will not take it amiss if I call attention to the spelling of Dr. Thaugheron's name. It is occasionally spelled phonetically, and as one whose name also suffers this fate from time to time, I am led to sympathize.

EDWARD H. KASS, M.D., Ph.D.
THORNDIKE MEMORIAL LABORATORY

Champion of Pineal Gland

To the Editor of the *Bulletin:*

Dr. Mark Altschule, in his Class Day Address "Lavender and Old Lucite," published in the January 1956 issue of the *Alumni Bulletin,* predicted that in 20 years or so "there will be fairly general agreement that the pineal gland is the seat of the Super-Ego." This statment adds to the long and imposing list of errata already accumulated concerning that much maligned and misunderstood organ. A few words in rebuttal seem indicated.

Although it would be foolhardy to question Dr. Altschule's lavender perspective at the top of his lucite tower, surely he must have been facing (in this instance, at least) in the wrong direction. Only a brief glance at the past would have revealed that Descartes declared that the pineal gland was the seat of the soul (the pre-Freudian equivalent of the Super-Ego*) well over two centuries ago. Even earlier, the Greek anatomists, particularly Herophilus and his followers, stated that the organ was a sphincter that regulated the flow of thought (again, functional representation of the Super-Ego). The pineal gland has long suffered as a result of such vile libels, and only the patient research of recent years** has transported the gland from the shadowy realm of the psyche across the blood-brain barrier to the land of the soma, where it rightfully resides. Certainly, for the future, in the interests of scientific and historical accuracy (Dr. Altschule will undoubtedly agree), another, perhaps more deserving structure might be selected as the basis for such invidious predictions.

JULIAN I. KITAY, '53

* Altschule, M.D., Personal communication.

** Kitay, J. I., and Altschule, M.D., THE PINEAL GLAND. Published for the Commonwealth Fund by the Harvard University Press, Cambridge, Massachusetts, 1954.

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HARVARD MEDICAL ALUMNI BULLETIN

VOL. 30 APRIL 1956 NO. 3

Letters 2
Some Accessory Factors in Medical Education . . 7
Let's Save the Goose that Lays the Golden Eggs . . 10
Readership Survey 13
Editorial 17
Greetings from the President and the Dean . . . 18
School Receives Duplicate of Medal 20
Inside H.M.S. — "The Distaff Side" 21
Faculty Meeting 24
The Facts About "The Facts of Medicine" 26
Medical Education in the Community Hospital . . 29
Bats in the News 32
Internships, Class of 1956 34
Honors 38
Book Reviews 39
Hans Zinsser Memorial Fund 40
Regional Activities 40
Alumni Day and Class Day Programs 42
Necrology 43
Alumni Notes 43

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Some Accessory Factors in Medical Education

An Address Given at the Alumni Day Symposium, 1955

Joseph Garland, '19

EDITOR, "THE NEW ENGLAND JOURNAL OF MEDICINE"



Dr. Garland

Having agreed on a brief presentation of my own selection of accessory factors for better or for worse in medical education, it seemed reasonable to find out, if possible, what this education is all about, over which there seems to be, at times, so much concern. The Hellenic idea of education as a preparation for the duties of citizenship—military, political, and religious—seems practical but hardly broad enough for the perplexing present. Perhaps it is less limiting to think of education as the result of those stimuli that set up a series of reactions in the human organization and have some influence in shaping the final character, as I discovered in one of my frequent lexicographic explorations.

Quite pertinent in this environment is our own Francis Peabody's statement regarding the relation of education to medicine, found in his lecture on "The Care of the Patient," first published nearly a generation ago. Medical education, according to this respected source, is less likely than are other systems to suffer from the stagnation of being left solely in the hands of teachers, "for whenever the lay public stops criticizing the type of modern doctor, the medical profession itself may be counted on to stir up the stagnant pool and cleanse it of its sedimentary deposit."

This is scarcely the occasion and the place for any gratuitous advice on the undergraduate curriculum, about which I know less and less as time goes on and on, having known next to nothing about it at any time. This problem I am quite ready to leave with the Dean and his Faculty and those informal advisers suggested by Dr. Peabody and for our purposes incorporated into the Harvard Medical Alumni Association. In this respect, the duties of the Association are plain, as set forth in its constitution, adopted before most of us were born; they consist of advancing the cause of medical education, promoting the interests and increasing the usefulness of the Harvard Medical School and promoting acquaintance and good fellowship among its members.

Regarding accessory factors in the development of undergraduate instruction, Dr. Berry has clearly indicated in the recent issue of the *Medical Alumni Bulletin* one of the most serviceable, and the part that the Alumni Association is expected to play and is playing, in its procurement. The reference, need I say, is to that fiscal stake that constitutes the motivating power of any organized educational venture. It might, in truth, be termed an accessory before the fact.

Distasteful as they may be to those accustomed only to a lofty professional idealism, these financial considerations are indeed indispensable to all but the most informal types of ed-

ucation, at any level. Since Dr. Berry has already outlined them so adequately, and yet so modestly in relation to the Medical School plant and what takes place in connection with it, it seems unnecessary to mention them again on this occasion.

What I should like to discuss is the relation of education to that unfinished product, the physician himself, and some of the accessory factors that seem to pertain to it. As the executive director of the Postgraduate Medical Institute has intimated in regard to such a relation in this area, the schools, hospitals, and other groups have made their individual offerings with apparent "disregard of each other's programs, with much duplication of effort, with overlapping of schedules, with unintentional neglect of certain subjects, with a paucity of publicity, (and) with inadequate attention to the actual wants and needs of the average practicing physician." If this is so, postgraduate education has in fact been a neglected offspring of the pedagogic process, despite a degree of progress in the development of graduate departments and the organization of graduate courses.

It has, nevertheless, come under various interested auspices, prominent among which have been the state and district medical societies and associations.

Through such channels the Institute, with its remarkable record of achievement in so short a time, came into being only three years ago, under the direction of the Massachusetts Medical Society. Its program has consisted not only of an up-to-date information service on all the available sources of postgraduate medical education in the area, but of a series of highly organized refresher courses and panel discussions conducted on a number of locations. These courses certainly do not represent the only, and may not represent the best methods of postgraduate instruction, but they do represent a sincere and dynamic attempt to meet a recognized need.

So engrossing has the whole subject become, in fact, that only a short time ago a panel discussion on "How to Make the Continuing Medical Education of Physicians Painless and Effective" was held as part of the annual revels of the Massachusetts Medical Society. The question may be raised if this is not dealing too much in contradictions, like having your cake and eating it. There are those who still believe that some sensation at least suggestive of pain retains a useful physiologic function, and in particular must be associated with the educational process; that the darker recesses of the calvarium are not opened without some complaint from the hinges of their portals.

The entire problem of postgraduate instruction is in itself a major accessory factor in medical education. So far as certain minor factors are concerned, various visual and auditory technics, mechanical in their origin and perhaps also in their reception, have come to occupy positions of increasing prominence and will some day require a realistic appraisal.

Film libraries, with all due respect to their undoubted value, may still be listed in such a category. A year or two ago, in this connection, the medical association of a prominent western state established a so-called audio-digest foundation with the purpose of recording on tape and visual strip current medical literature and lectures. Within a short time weekly one-hour tape recordings were summarizing current medical literature from 600 journals, nor have the fountains ceased to spout. Plans were then put on foot for a medical lecture library containing material designed to perpetuate until the end of time the ruminations of the leading professors in all the medical schools of the country. This would encompass, according to the sober announcement, "the entire field of medical education."

The transcontinental closed circuit television clinic is still in its infancy but already the hope is being expressed that the vast sums required by this form of supererogation may some day be directed more wisely to the basic requirements of medical instruction. And in this relation I suggest a study of the symposium on corporate support of higher education that appeared in the late May issue of the *Harvard Alumni Bulletin*.

The payoff, however, is the vocal element of the tape-recorded medical library, designed to sit beside the physician in his car and insinuate into his consciousness, as he threads his way through the world's heaviest traffic, precise abstracts of the world's most honored medical literature. Nor does reversing the key result in any rest or relaxation; it simply enables him to dictate the products of his own cerebral activity, if any. Dedicated as is his great heart to the unremitting task of serving others, there is for it no diastolic phase however momentary.

A consideration of these contrivances makes me hesitate to mention that ancient symbol of communication, the printed word. And yet, despite the electronic devices that so casually reveal the most exciting episodes in the melodrama of modern medicine there appears still to be a constant and even a growing demand for the stuff that eventually finds its way into libraries.

So stable is this demand, in fact, that the Boston Medical Library, having successfully raised a fund to expand its storage facilities, now seeks an endowment to maintain them, and our own School library seems to require even more impressive sums for its future growth and operation. Perhaps it is not too much to hope that eventually a plan may be envisioned that will include in a single informal *civitas Hippocratica* all three of the schools as well as the hospitals of the area, with the Boston Medical Library as the central repository of the intellectual archives.

Textbooks are still being written, read, revised, and relegated to the

more inaccessible stacks, but my reference to the printed word is not to its use in the textbook—that omnivorous organism whose only change after its brief passage through living tissue is a gradual and permanent encystment. I refer rather to the lively, instructive and entertaining pages of modern medical journalism where viable cultures of fresh knowledge are periodically decanted into new and limpidly transparent vessels. This accessory factor is, I am sure, of obsessive importance to at least one among us.

Being agreed, then, on the major role that periodical medical literature plays in medical education, we will no doubt also agree on the necessity of some winnowing process among the 9000 or 10,000 journals in current publication. The majority of them no doubt serve some useful purpose, since nature is said to abhor a total vacuum, and there is no question that the many special journals fill the special needs for which they are designed. The educational value of the general or all-purpose journals is subject to closer scrutiny, for they are, in general, more vulnerable in their attempts to perform a more diversified service and serve a more varied readership.

During a symposium on medical journalism held a short time ago at the Royal Society of Medicine, Fox, of the *Lancet*, addicted to gentle irony, declared that the function of the medical journal is now to record rather than to inform. The proliferation of journals, he said, has become almost a malignant process, which has been described by the term "journalistic blastoma." He regards the *Lancet* as a general medical newspaper aimed at integrating a profession that is in danger of falling apart, a function that his periodical is apparently performing with dispatch, for, while riding on a train, he had seen a skilled reader run through its pages in seventy seconds.

Those who are responsible for the continued usefulness of a general medical journal may well ponder on its true functions, which are certainly to inform as well as to record. I can only repeat the words of the editor of the *British Medical Journal* in which he defined the function of a general journal as that of supplying in each issue not everything for some of its readers, but something for each of them.

The editors of the *New England Journal of Medicine* may attribute what success they have had in producing an instrument of educational value to the fact of its being edited and published in this same *civitas Hippocratica* that surrounds us. Here alone can one find that happy blend of independent thought and inspiring tradition that has made available the Case Records of the Massachusetts General Hospital, recognized wherever English is spoken as comprising one of the educational marvels of the century. From this academic nidus and from many other centers of medical culture whose scientific aspirants occasionally turn their eyes in this direction, our *Journal* derives a variety of original material resulting from independent research, reports of progress in the various divisions of medicine and surgery, and selected special articles of paramount importance.

That such material constitutes a major accessory factor in postgraduate medical education can hardly be doubted; that it has some bearing on the education of the undergraduate as well is attested by the fact of nearly 7000 undergraduate subscribers to the *Journal*. Let me add, however, that any undergraduate approbation of our editorial policies is no more unanimous than is that received from their less sophisticated elders. The following excerpts from a letter written by a serious young person in New York who had apparently taken out a student-rate subscription in an unguarded moment put us in our proper place.

* * *

Sirs:

Please discontinue my subscription to the *New England Journal of Medicine* as of now and return what remains of my subscription price.

If I may give a reason for my action, let it be this. I am disappointed in your magazine as a source of education. The articles published are of extremely limited interest. Take as an example the first article in this week's edition, "Tuberculosis and Parasitism as Causes of Abdominal Pain in Korean Patients." Do you send many editions to the far East?

A recent article on "Radiologic Examination of the Gastrointestinal Tract" was, to my mind, woefully inadequate, going to ridiculous detail in some aspects and skimming over far more important matter.

These, sirs, are a few of my thoughts on your magazine. Your publicity and advertising led me to believe that it would be a help to me as a medical student.

* * *

In the face of such strictures, the pious adage "Whom the Lord loveth, He chasteneth" seems to us a sensible creed by which to operate. And so, with increased humility, we have tried to carry on.

In closing I should like to tie these random ends together by reminding you again that at the other side of the Fenway there exists a sort of rudimentary Hippocratic City within the greater one. Here the continuing education of the physician is slowly evolving through the industry and the facilities of the Boston Medical Library, the *New England Journal*, the *Journal of Bone & Joint Surgery*, the Postgraduate Institute, a couple of conservatories of music, and the Massachusetts Medical Society, which, in a manner of speaking, broods over them all. And the continued stretching of hands across Muddy River, even to the extent of an increased representation in the Society of those who are devoting full time to teaching, is sure to serve a doubly useful purpose.

Let's Save the Goose that Lays the Golden Eggs*

Robert Cutler

CHAIRMAN OF THE BOARD OF TRUSTEES OF PETER BENT BRIGHAM HOSPITAL AND CHAIRMAN OF THE HARVARD UNIVERSITY BOARD OF OVERSEERS' COMMITTEE TO VISIT THE HARVARD MEDICAL AND DENTAL SCHOOLS.

Almost two centuries ago, Dr. Samuel Johnson, the Great Lexicographer, wrote this in his broadsheet, The Idler:†

> "Among those actions which the mind can most securely view with unabated pleasure, is that of having contributed to an hospital for the sick."

It should be our objective, Gentlemen of the House of Delegates, to make it possible for such unabated pleasure to be experienced by generous generations still unborn.

But the way of accomplishing this fine objective is beset with difficulties. Especially is this true in the case of University teaching hospitals supported by voluntary funds.

Of course, *all* hospitals worthy of the name are teaching hospitals, whether they have twenty beds or two thousand beds. And I know that every doctor worthy of that title is a teacher. But tonight, when I use the term "teaching hospital," I am thinking and speaking only of University hospitals in which medical students receive their clinical training.

Let us get down to brass tacks. Anyone who for almost two decades has been successively the Chief Financial Officer and the Chief Executive Officer of a University teaching hospital is as full of brass tacks as St. Sebastian was of arrows.

The fact is that our voluntarily-supported hospitals are caught in the Big Squeeze. They are caught in that shrinking space between the upper millstone of collectible charges to patients and the nether millstone of skyrocketing operating costs.

Sometimes it seems as if every hand was against the viability of voluntary hospitals. The Legislature passes each year some one or more laws that increase our burdens. The economic cycle pushes up the cost of services, of food, of supplies. And then our best friends, the doctors, keep on discovering and inventing new wonder-drugs, new mechanisms, new necessities for the saving of human life. God bless you for your matchless skill. God forgive you for what that skill does to a Trustee's peace of mind.

And upon the University teaching hospitals of America a new burden has come crushing down since World War II. This burden, the child of increased research activities and increased costs related thereto, is what I want to talk about to you tonight.

The Brigham Hospital has three functions. One is to care for the sick. The other two buttress and support the first, and suffuse with light the dark places. These other two are: to teach those who will become the doctors and the nurses of tomorrow; and to advance by exact, inspired, and researching skill mankind's store of medical knowledge.

As a Trustee, I sometimes seem to alarm my great Professors with my consciousness of the cost of research. But they really know better.

Beyond any shadow of doubt, I march under the banner of inquiring research. In a University Hospital, research is the pulsing arterial blood of life. It is the vital essence, as important to such a hospital's place in the scheme of things as breath is to the nostrils of a living man.

And I glory, as a lay brother, in the accomplishments of America's teaching hospitals. To salute what they have achieved is not intended to, and does not in any way, detract from the solid achievements of our other great hospitals. In this work, it is easy to find enough stars for everyone's crown.

But I do say that the voluntarily-supported University teaching institutions are, by their performance, a front-line in America's care for the sick, today and tomorrow. Here are the geese which have been laying the golden eggs of medical discovery. And it is of primary consequence to the progress of medicine that these precious birds be assured in the years ahead of every opportunity for reproduction and for lying-in.

One of the difficulties to which I earlier referred, confronting voluntarily-supported medical schools and their affiliated hospitals, is the magnitude of cost to the school or the hospital of the research activities which they now carry on.

President Conant, in his 1950-1951 Annual Report for Harvard University had this to say of the broad implications of expanding research expenditures:

> ". there are limits to the amount of temporary money that should be expended by any department of the University. No blanket rule can be laid down, but clearly permanent appointments in any area financed by temporary grants are in reality a liability against the unrestricted income from endowment of the entire University—an amount that represents but a small fraction of our annual income. Furthermore, commitments may become permanent in a university without any official action—moral commitments are so

† The Idler, No. 4, May 6, 1758

* Reprinted in part, with permission from the *Journal of the American Medical Association.* Originally an address before the A.M.A., Nov. 30, 1955.

readily developed to this or that enterprise. Every proposal for expansion must be scrutinized with great care, therefore, to see whether or not it places in jeopardy our permanent resources. Many a worth-while project supported by only a five-year grant or annual giving must be refused."

These words were written at a time when Federal expenditures for research and development in *all* fields totaled only $1.3 billion a year. In Fiscal Year 1954, the last full year I was in Washington, the Federal Government alone was expending about $2.2 billion on such research and development.

This golden outpouring flows also from foundations; from trusts; from industry; from individuals; from funds raised annually to combat specific ills such as cancer, heart, polio, and so forth.

What are some consequences of this shining inundation?

In the Annual Report which I rendered last week to the Board of Overseers of Harvard College, as Chairman of the Board's Committee to visit The Medical School and The School of Dental Medicine, I said this:

"In 1910, the School's 'hard money' income was ten times its 'soft money' grants and gifts; in 1954, the 'soft money' exceeded the 'hard money.' More and more, as time goes by, the School is forced to carry on its high calling upon a foundation of sand which may shift away. There is no assurance that these governmental and other research grants—with their inadequate provision for 'overhead'—will continue their support through the long look ahead."

Let me repeat. In FY 1954 the Harvard Medical School expended *more* from gifts and grants from outside sources (what we call "soft money") than it received from students, from endowment funds, and from other University sources (what we call "hard money").

This great largesse of research funds is a heady wine. As Dr. Conant said, the very size of this research money requires that each project be scrutinized over and over again with great care, not only to determine its individual merit but also to be sure that its acceptance will not throw us out-of-balance and place in jeopardy our permanent resources.

But let me descend from this upper plateau of educational policy to the rocky lowland of fiscal reality, upon which first breaks the incoming tide of research money.

In my Report to the Harvard Overseers I made reference to the inadequate provision in research grants and contracts for overhead or indirect expense.

Now, ladies and gentlemen, the curtain is going up on the Third Act. This item of unreimbursed overhead expense in relation to research grants is Peck's Bad Boy. It is of this unseen, but omnipresent, fellow that I want especially to speak.

The crucial nature of this problem is revealed by looking at the expenditures for research made in a particular year by the Harvard Medical School and its affiliated voluntarily-supported Hospitals, the complex which we call the Harvard Medical Centre. In FY 1954 there was expended from funds which had been given to the members of this complex for research a total of $5,130,000. Fairly computed, the overhead charge attributable to this great sum came to over $1,500,000. But those who had provided so great a sum for direct research expenses had provided only $513,000 for indirect expenses. Accordingly, about a million dollars that year had to be taken from the strained general funds of the members of the Harvard Medical Centre.

Look for a moment at my Brigham Hospital, one member of the Harvard Medical Centre, and how it fared in the same year. From funds given to it or to the Medical School for research projects to be carried on within the Hospital, there was expended on direct costs of these research projects more than $700,000. Overhead or indirect expense related to these direct expenditures approximated $235,000. If we include in such overhead only out-of-pocket expense, and make a contribution of use of facilities, the figure comes to $190,000. However, the grantors of the research funds provided towards overhead only about $51,000. Thus, there resulted an overhead deficit of some $140,000. The cash to meet this deficit came from the general funds of the Hospital and the School; thereby further diminishing for the next year their "hard money" endowment income.

This is the way to kill the goose that lays the golden eggs. This is the way to commit "medical research suicide," with both your eyes open.

What we are talking about, you see, is not a frill, or a trifle. We are talking of the central supply of blood to the heart of medical research. A million dollars a year in unreimbursed research overhead at just one medical teaching complex! In the American vernacular, "that ain't hay."

This situation prompted Dean George Berry to write, in his penetrating article, "Financing the Harvard Medical School," published in the April, 1955, issue of the *Harvard Medical Alumni Bulletin*, as follows:

"In the last analysis, the problem is to devise the way to make ourselves able better to afford our large research activities."

There *is* a way to make ourselves able better to afford our large research activities.

Several years ago Harvard University retained the best accounting brains it could find to devise sound methods of computing the direct and indirect (or overhead) expenses of each of its component departments and institutions. The accountants' report furnished to the Harvard Medical School and to each of its Affiliated Hospitals a Formula which, when applied to a research grant or contract, would give the percentage of overhead expense related thereto. This Formula is simple in concept. It proceeds on the familiar basis that the

three principal factors in computing indirect expense are: administration and general expense; operation and maintenance; and use charges or depreciation.

We Boston institutions have been making computations based on this Formula for several years. Today each element of the Harvard Medical Centre knows exactly what its overhead expense is, in detail and in total. Today, we are well equipped to place research operations on a hard basis of fiscal fact and remove them from the preexisting area of speculation. We are in a documented position to demonstrate to those who provide research funds just what indirect expense reimbursement should be furnished if our institutions are to be able to carry on in the years ahead. And we shall try to stand together in carrying out such a sensible and prudent policy, which will work for the good of all and the good of each.

For some time now, the policy of the Defense Department and its component Services, and latterly the policy of the Atomic Energy Commission, has been to pay to the recipients of their research funds an amount for overhead expense computed according to these same accounting principles. The application of these principles is a realistic approach which should be generally acceptable to all.

In the spring of 1955, a Special Committee appointed by the National Science Foundation to study for the Federal Government this overhead expense reinbursement problem, filed its report. The Special Committee recommended that the Federal Government adopt in the future an overall policy relating to reimbursement of overhead expense to grantees and contractees of Federal research funds. This new policy would offer to recipients full or substantially full reimbursement for indirect expenses on the basis of sound accounting principles.

This sound and farsighted recommendation was hailed by those of us who have been laboring in this vineyard for the common good. Leaders in the Eisenhower Administration have shown sympathetic appreciation of its validity. We earnestly hope that the Federal Government will adopt such a policy, as a part of its next Fiscal Year Budget. Those of us who can are doing more than hope: we are telling the story in every ear at every chance.

Adoption by the Federal Government of the recommended realistic policy for reimbursement of overhead expense would have two beneficial effects. The National Science Foundation and the Public Health Service, now reimbursing 15% for overhead expense, would raise their standards to those already in effect at the Pentagon and at the Atomic Energy Commission. And the pattern thus uniformly set for Federal grants could be expected to have a deep impression upon Foundation, Fund, and Industry grantors.

Some of these latter givers already sincerely understand that teaching institutions, like a fagged-out horse, cannot run the victorious race if made to carry too large a burden of indirect research costs.

I venture to say that no single act by the Federal Government could mean more and give more hope to the teaching institutions in connection with their medical research activities than Federal adoption of such a realistic general policy for reimbursing overhead expense. With this guiding light to follow, all of us who have responsibilities in this area would be encouraged, and better able, to spread a gospel to all non-Government grantors of research funds. Marching together in a realistic Educational Crusade, we should surely attain a goal of stronger research programs in stronger institutions.

Let me add a point which I have made to persons in high authority in the Eisenhower Administration. I believe sincerely that, in a free democracy like ours, the grantor and grantee in a research project should be "partners." My Hospital does not ask that it be reimbursed for its *total* overhead expense. We wish to share in the project, over and above our contributing the high skills of our Professional Staff. To that end, we are willing to give so much of our overhead expense as is within our means. And the Trustees of the Brigham Hospital have now adopted as policy a Declaration to this effect.

I ask each Delegate to consider and understand this critical situation in medical research and medical education. Will each of you join as an evangel to the givers, grantors, and contractors, public and private, of research funds, an evangel to tell of the need to place reimbursement for research overhead expense on the realistic basis which I have described? If you will, you will be helping to make American medicine even stronger tomorrow than it is today.

Many people are accustomed to believe only what they feel or see. The doctor doesn't feel or see the overhead expense. But we Trustees do. This villain is not hidden from us. He turns up every night in the Treasurer's office to devour our "hard money" resources.

For me, at least, research will have its "golden age" when the grantors and contractors who provide for direct expenditures will as equitably and realistically provide for indirect expenditures. Then, indeed, our medical research goose will be able to continue, for time untold, to lay the golden eggs of discovery.

All of us here tonight want the same thing. We want to make the sick well. We want to push back the frontiers of medical knowledge. We want a bubbling fountain of medical research. We want America's voluntarily-supported institutions, trie precious mechanisms for the advancement of knowledge, to thrive on in the future as in the past.

We can better have these things if those institutions which carry the heavy load of medical research undertakings are enabled to do so on a basis that is realistic under existing circumstances and that takes into account their slender capacities to pay. For in this way, their matchless spirit and their valuable facilities will be preserved to work for the generations that are still to come.

Readership Survey

The January issue of the *Bulletin* contained an insert calculated to drop gently into the reader's lap when the magazine was opened. Printed in the form of a questionnaire on a franked and addressed envelope form, it could be answered, sealed and dispatched within a matter of minutes. Its purpose was to obtain an idea of how many of the recipients of the *Bulletin* actually read it. This information in turn was calculated to lure and entice prospective advertisers. Sandwiched between questions whose answers were of importance to our planning were questions proposed for the express purpose of interesting or angering the reader sufficiently to answer the others. The results were most gratifying. As this issue goes to press with questionnaires arriving daily, we have heard from more than 30 per cent of the 5500 recipients of the *Bulletin*. This is a remarkable response for a readership survey in which a 10 per cent return is excellent by commercial standards.



What else would you like to see in the Bulletin?

Occasional reporting of Harvard Medical Alumni and their activities out of Boston. Harvard men don't die when they leave Boston.

Other comments:

I had a glow of pride while en route to work, reading it on the subway....





What type of practice do you do?

Psychiatry

Should we charge for it?

Most things are more valued if paid for



Other comments:

AREN'T THERE ANY OLD-FASHIONED PHYSICIANS LEFT WHO MODESTLY TAKE CARE OF PEOPLE WITHOUT THOUGHTS OF ADVERTISING, RADIO, AND TELEVISION

What type of practice do you do?

US Navy

What else would you like to see in the Bulletin?

Naked women or a five dollar bill





What type of practice do you do? Ophthalmology

Other comments: It looks good on my desk

The replies to the questionnaire were postmarked from 45 states and from Puerto Rico, Mexico, England and France. Most of those who took the trouble to answer read the *Bulletin* thoroughly (91 per cent). Seventy-five per cent did not want scientific articles and about the same number thought we should not charge for subscription. Our correspondents were lavish with suggestions including the desire for more pictures, more news of the faculty, more news of students and more articles by practitioners. Many wanted more humor and some consciously or unconsciously contributed some of their own which is illustrated herewith by Dr. Ernest Craige, '43A. In general, the readership was favorably impressed with the *Bulletin* and even at times enthusiastic. Some, if not enthusiastic, were at least emphatic (vide infra) and this is just as important in a readership survey.

Should we publish scientific articles in the Bulletin?

No! 1000 times NO —

Editorial

HARVARD INDIFFERENCE

The Alumni have recently received a ballot on which they are asked to choose three new members to serve as Councillors of the Harvard Medical Alumni Association. If the response this year is like that of the past two, we can confidently predict that more than two-thirds of the Alumni will do nothing more than look at the ballot and fail to return it. The reasons for such dreadful dereliction, we surmise, are inertia, procrastination and indifference. Inertia is one of the basic principles of physics and little can be done to abolish it, beyond supplying return-addressed envelopes. Of procrastination, little need be said except to remind our Alumni of that profound maxim of Archy, "Procrastination is the art of keeping up with yesterday." Of indifference, we would write today.

The Council is the governing body of our Alumni Association and should represent, so far as possible, the many points of view that characterize any Harvard Alumni group. If only thirty per cent of our Alumni vote, can such a council be considered representative, particularly in view of obvious limitations imposed by geographical factors?

The Council does not merely represent Alumni opinion in a vacuum. It serves as a point of contact between the administration, usually referred to as the "Dean's office," and that great body of graduates who have a continuing interest in the development of the School particularly in times of crisis and change. At the moment, such crisis and change is predominantly in the financial field, and in this the Alumni have responded magnificently. In response to the Alumni Fund, nearly sixty per cent contributed—only thirty per cent voted! A rather strange paradox!

One may ask, doesn't thirty per cent represent a better than average voter response? As a matter of fact, it is quite comparable to the response to a similar ballot sent out to Harvard College Alumni, but as an argument, this is a two-edged sword. More convincing, perhaps, is the statistic reported under an Associated Press dateline in the *New York Times* of December 13, 1952; namely, that in the last national presidential election, sixty-three per cent of the adult population voted. We believe that our Harvard Medical Alumni are, by and large, an adult population and for this reason should vote for the councillors of their Alumni Association.

J. G. S.



Joseph T. Wearn, '17, President of the Alumni Association

Greetings from the President...

This year Alumni Day will be held on Thursday, May 31, 1956, and every one of you will be most warmly welcomed. Last year, about 800 Alumni attended and heard a thrilling scientific program presented by members of the Faculty in the morning, and then enjoyed a delightful buffet luncheon, held outdoors in the Medical School quadrangle.

Alumni Day furnishes the one opportunity each year for the Alumni to meet the Dean, his administrative staff, members of the Faculty, classmates, and friends. It also affords an excellent opportunity to see first-hand the important new developments taking place in medical education, the latest changes in the school buildings, and the many interesting scientific advances.

But more than that, Alumni Day 1956 has a special importance for all of us. Fifty years ago, President Charles W. Eliot formally dedicated the present site of the School. In his speech of acceptance, he noted that the new property, together with its accompanying endowment, constituted the most valuable single addition to the University since the receipt of its charter in 1650. This is an anniversary of great significance, due note of which will be taken during the program which has been planned.

I can guarantee that you will be richly rewarded by returning for this particular occasion and I shall look forward to seeing you at that time.

Joseph T. Wearn, M.D., '17
President of the Alumni Association

...and the Dean



George P. Berry, M.D., Dean of the Faculty of Medicine

Alumni Day is important—at any school, at any time! But some, for a variety of reasons, may have special significance. Such is the case this year at the Harvard Medical School. On Thursday, May 31, we shall be celebrating fifty years in the Longwood Quadrangle. This year also marks the fiftieth anniversary of the granting of a charter to the Harvard Chapter of *Alpha Omega Alpha*. It is interesting, too, that the Class of 1931, which will be celebrating its twenty-fifth anniversary, was the first class to enjoy the privilege of spending four years in Vanderbilt Hall.

Quite apart from any special significance that may pertain to this year, Alumni Day is becoming more and more important to each of you—and thus, to Harvard. I say this because of the growing numbers of graduates who have been coming back in recent years. Increasing numbers are thus not only having the pleasure of reliving bygone days with old friends, but are simultaneously learning more about the School's programs and taking an active interest in them.

When you come to visit us next May, you will find that much has been done in the Quadrangle since many of you left to practice your profession in other parts of the country. Extensive renovations in Building D have provided much-needed new laboratory space and a comfortable, modern amphitheatre. The hospitals academically associated with the School have many new facilities. Many other improvements have been planned—some are under way. But come to see for yourself!

To this word of invitation, let me add a personal word of welcome on behalf not only of myself but of your teachers. All of us are looking forward to the opportunity to greet you on Alumni Day. So, if Thursday, May 31, is not already reserved on your calendar, please check the date in red right now.

George P. Berry, M.D.
Dean of the Faculty of Medicine



David Lawlor

Dr. Berry, Dr. Charles Janeway, and Dr. Robert Debré

School Receives Duplicate of Medal

A unique treasure has recently been added to the Medical School's prized collection of historical memorabilia. The gift, a newly struck bronze duplicate of the first medal ever ordered by the American Congress, was presented to Dr. George P. Berry by Dr. Robert Debré, Director of the Medical Clinic in the Hospital for Sick Children in Paris, Professor of Pediatrics at the University of Paris, and a member of the Executive Board, United Nations Children's Fund, during a recent visit to Harvard. Dr. Debré, who spoke to members of the Faculty of Medicine and the student body on problems relating to the diagnosis and treatment of tuberculosis in children, had the medal struck from the original die now carefully preserved in the Museum of the Mint in Paris.

The original gold medal was ordered by Resolution of the Congress on March 25, 1776, for presentation to General George Washington in token for his service as Commander-in-Chief of the American Army. The face bears a relief of Washington's profile encircled with the inscription: "The American Congress to George Washington, Commander-in-Chief of the armies, the assertor of liberty." The reverse shows Washington and his staff, with the American Army in battle array, watching the British fleet evacuate Boston. This side is inscribed: "The enemy put to flight for the first time—Boston retaken, March 17, 1776."

At the request of Colonel David Humphreys and Thomas Jefferson, the French Academy of Inscriptions and Belles Lettres appointed commissioners to design this medal. The engraver, Pierre Simon Duvivier, was then Engraver-General of the Paris mint, and the medal was struck in France because of inadequate mint facilities in the Colonies at that time.

Recent graduates of the Medical School will appreciate the special appropriateness of Dr. Debré's gift when reminded of the annual Christmas ceremony at which the Benjamin Waterhouse clock is wound.

In 1783, Dr. Waterhouse became first professor of the theory and practice of physic in Harvard Medical School. Shortly before the British evacuated Boston in 1776, Dr. Waterhouse had supervised the inoculation of approximately 1000 of Washington's troops against small pox, a disease then ravaging both forces. Later, he pioneered in the first vaccination program in the Colonies, a procedure discovered by his close friend, Edward Jenner.

The clock, acquired by Dr. Waterhouse in 1790, was presented to Harvard Medical School by his great-granddaughter in 1950, and at each Christmas party since that time, the medical students have taken turns giving the clock its once-yearly winding. They have also had an opportunity to view the snuff box and vaccinating scarifiers sent to Dr. Waterhouse by Dr. Jenner, and now owned by the Medical School.



David Lawlor



Inside H. M. S.

THE DISTAFF SIDE

Fran Memmo and Joanne Lafferty

There was an old student who lived in a book,
His eyes trained to Mecca; son ne'er got a look.
His long suffering wife he met only in bed
Not his "love" but a patient to test toe to head.
And why be distraught, it's so worthwhile you see,
When it's over, my dear, he's a Harvard!! M.D.
But that's only the start as you sorrowfully learn
For where, oh dear where, is he going to intern?

Pearl Pollack Rosenberg '56

Yes, the soul-searching and tantamount question facing the wife of a medical student who by virtue of his innate ability and hard work has reached the magic fourth year is that of internship. Husband and wife have combined forces some time ago and with much concerted effort on both parts they have now come to the end or what they feel to be the ultimate aim—that of graduation from medical school. And now, of course, they find it is the beginning of their real purpose.

But since this is the feminine-eye view of medical education, let us go back and see what these wives did and how they looked at the highest form of graduate education when they joined forces with their future doctor. Particularly let us examine how they felt about Harvard.

This is no small group who have come from all parts of the country to live and share in this community. The married couples number over one third of the total enrollment and the percentage is increasing by the year.

In the first year we find few of our wives fulfilling the wifely aspirations of homemaking and "child loving." Many more are using their talents to keep a roof overhead and soup on the shelf. Teaching as well as secretarial positions are high on the list of enterprises. There are many wives doing library work and some who are nurses and technicians. In the group of wives it is not hard to find those who are students themselves pursuing a separate endeavor. All are busy. Most are learning to squeeze the ironing and washing between dishes and meal planning before returning to the job that keeps all going. Besides the routine as new wives, they are trying to achieve well designed apartments, and of course, making an effort to get acquainted with the people in this medical life—both wives and husband's colleagues.

The wives, whether they find time in the first year or later on, discover that the Wives Group is worthwhile. It is organized for the express purpose of bringing together those in similar circumstances with similar interests and problems. And so it prospers.

Our first year wife and her husband receive an invitation in early October to a punch party. It is on a Tuesday evening. Upon arrival at the first of The Wives Group activities, they find to their surprise and pleasure scores of couples equally eager to get acquainted. With the initial meeting behind them the males are left to their books, and the remainder of the year the wives gather to enjoy evenings of enlightenment and conversation on many a common problem. The first year wife has many friends and partners in crime now who will listen to her views and sympathize when she registers disdain at the odor which follows her husband home from the anatomy lab or when she relates what a

Editor's note: Some time ago a questionnaire was sent out to the wives of all Harvard Medical students in an effort to get an accurate picture of how it feels to be the wife of an H.M.S. undergraduate. The results of this questionnaire were made available to the authors of this article who culled from them and from their own experience a composite portrait of life on the distaff side of Harvard Medical School.

difficult lesson it is learning not to chat of the day's events to the one person with whom she really wants to talk. But she is learning to take it all in stride.

At the next annual punch, the new wives are greeted and the second year wives find their group has increased considerably. There are still many holding full time jobs away from home. But as the wives look around they see that many more children are promised or have already made an appearance since last June. Many faces are familiar now and they are glad to meet the new.

Our wives enjoyed being thrown into a specialized and scientific atmosphere. For most it was a little awesome at first, but now as second year wives they feel somewhat more at home and are even able to undertake the pronunciation of some of the medical terms to which they listen daily at the dinner table. They seem to understand better the difference between Bacteriology, Pathology, and perhaps Biochemistry. It is even possible in one of those tête-à-têtes with a fellow student for a wife to detect the subject of the conversation from reference to the text referred to, of course, by author alone, *Anderson*, *Gray's*, or *Grant's Atlas*. And naturally the wife likes nothing better than to get together in the Wives Group and talk of these mysterious vistas and in some way with the other wives to shed some light on her husband's expanding knowledge. For she wants nothing more than to be able to understand even in a minute fashion what he tells her with such enthusiasm.

As the second year progresses the wives realize that tension has increased with the increase of work load and frequency of exams even to a greater extent than in the first year. At the Tuesday evening meeting this subject is discussed with concern. There is a wish to keep household duties running smoothly and in some way lessen the load. It is felt that Harvard is very wise to keep grade importance to a minimum with the secret grading system. The wives feel somewhat strengthened with this knowledge.

Not all is serious in the life of our second year wife for another party is in the future. With the holiday season comes the Wives' Christmas party, and of course, husbands are in full force along with Santa, who delivers gifts of food to needy families of Boston and even finds a few well loved packages for the Med School couples. As the wives survey the group they decide the struggling students aren't so struggling and become well rounded and congenial husbands at the right time.

By the end of the year she sees that the struggling through these first two years has not been for naught, since at this time her husband and the entire class have a chance to prove their work worthwhile when they take the first part of National Board Examinations which will in the future give them the right to practice. And she feels at this time that she would be proud to have any of his classmates for her own doctor. Her expectations grow as the clinical years begin.

The journey halfway through medical school has ended. The opening vista is bright! The third year student, with a gleam in his eye and a stethoscope in his pocket, begins to apply that which he has assimilated in the amphitheater during the past two years.

The third year wife too, has a special "light" in her eyes. This is the result of her husband's ophthalmoscope. This and many other instruments are promise of relief to the physically ill, but to the medical wife they are implements of torture. She no longer is requested to read, sew or iron peacefully by herself. Her knees become the target of numerous blows of the little rubber hammer; her back becomes a sounding board while she patiently repeats, "99,99,99."

However, the little woman does not complain too loudly, for she is eager to offer some tangible assistance, but most of all grateful to receive personal attention. She has learned to appreciate any kind of attention, for now that her husband is taking on hospital duties, she may not see him for days at a time, especially when he is on OB.

This information, along with other tales of what is to come, she has acquired at the Harvard Wives meetings. Here her misery finds company. Most important, she finds her normal place within a group of stimulating girls. Looking around, the third year wife discovers many new personalities wearing a third year tag. They are the wives of transfer and newly married students. The number of married couples has doubled since the second year and the babies are on the increase.

Both husbands and wives have received benefits through the Wives organization. Many have received information leading to apartments, jobs, and baby sitters. The variety of speakers at the meetings offer entertainment and enlightenment on many subjects. Last year Dr. Sturgis spoke to the group on Problems of Sterility. He was followed by Dr. Kirkwood and a discussion on Natural Childbirth. These were obviously two most impressive speakers. This year the girls expressed an enthusiastic wish to hear Dr. William Berenberg speak on phases of pediatrics.

Dr. Kerr supplied a movie, as well as a talk on Cancer. This year, the wives were most privileged, to be given the opportunity to hold one of their meetings in the Jimmy Fund Building. For this arrangement we must thank Dr. Farber, who personally spoke to the group, showed slides on the organization and workings of the institution, and provided a tour through the labs and other rooms of the building. Such programs provide the wives with medical material which they can proudly and intelligently discuss with their husbands and mutual friends.

The inner sanctuary of the Faculty Conference Room in Building A was made available to the wives for another informative meeting. Here Dean Berry provided facts and figures concerning the history of HMS and

the complexity of the administrative and financial problems of a large medical school. Such time given personally by the members of the faculty, and the information they have imparted, provides the students and wives with a greater appreciation of and loyalty to the school.

On the agenda of the Wives Organization, there have also been meetings of a less academic and more broadening nature including talks on contemporary furniture and design, elementary education today, book reviews and a piano recital by a member of the present fourth year class, Dick Sogg, who played selections of Beethoven, Debussy, Ravel, and Chopin. In addition there has been a reciprocation with the Dames group of Harvard University and both the Law and Business School Wives, in the form of invitations to meetings at which Archibald MacLeish and Charles Hopkinson, a New England portrait painter, were speakers.

All in all, both student and wife benefit from the rich cultural, social and academic atmosphere embodied in the close association of couples with each other, with the faculty and with other divisions of the University.

If he has not found it necessary previously to benefit from another of the medical school facilities, the financial aid program, many a student has occasion to turn to it by the time he has reached his final year. As an inevitable result of the natural processes of married life, the fourth year finds that a good proportion of the married couples has acquired "deductions." The class of 1956, for instance, which has 62 married students, also boasts of 40 heirs. It is obvious that the fourth year wife has ceased to be the bread winner in many a household. Those in this situation benefit most from the financial assistance which Harvard makes available.

As the clinical training progresses through the fourth year, the wife advances in her prospective role as a doctor's wife, while her husband continues to gain confidence and skill. At first she finds it difficult to adjust to his unpredictable schedule. However, before long the homemaker has mastered recipes which can be prepared at a minute's notice. During meal time and afterwards, the wife eagerly listens to descriptions of cases encountered on grand rounds or in the OPD.

Babies, finances, "striking," jiffy meal planning, are only minor problems of the fourth year medical household. Where should he apply for an internship? In what order should he rate the hospitals? Where, oh, where, will they end up? These are the questions; questions which remain the nightmare for both wife and husband. Schedules and budgets become strained as the doctor-to-be travels to prospective hospitals for interviews. One by one, each problem is eventually solved, as the due date for mailing preference lists arrives. However, during the weeks which intervene between the end of January and March 12th, there is a mounting of tension and anxiety. Time heals all. The tidings of March 12th bring on gaiety and celebration, for even if the student has suffered some disappointment in his choice, he and the little woman at least know of their future destination, and can plan accordingly.

With commencement time drawing nigh, the fourth year wife looks back over the days she and her husband have shared at Harvard. Yes, there were lonely, blue moments, and problems too, but the joys outshine them all. She is happy that they came to Harvard where her husband received a superior education in medicine. Not only have they been recipients of the benefits of the University itself, but also of the community. The symphony, theaters, museums and art galleries had much to offer these young people.

Inwardly, the medical wife feels a great deal of pride toward her husband's profession. It is a demanding position in life, but there is a definite place in it for her. Her feelings have been summed up in the following poem written by one of the present "fourth year" wives.

"OFF" AND "ON"

Oh! *I'm* alone another night,
Well I don't care, I'll sit and write.
I'll tell this world just how it feels
To sit alone and eat one's meals.

He's "on", he's "off", he's "on" again,
And he'll be home, *I* don't know when.
There's not one way that I can plan
Exactly when I'll see *my* man!

The alarm goes off and so does he,
And nothing's left but the bed and me.
And then at night when I come home
You think he's here—no, I'm alone!

But just when I have gone to sleep
In the front door I hear him creep.
"Hello", I say, and then "Good night".

You think I mind when he's not here?
You think I wish that he were here?
You silly one, of course I do—
But can't sit 'round and just boo hoo.

For he's a student clad in white
"Off" in the morning "on" at night.
And lonely or not this is the life
I bargained to get when becoming his wife!

(Secretly though, when friends ask in doubt
"Are you both home?", "Can you come out?"
There's a thrill when I say he's to hospital gone,
And I'm proud to reply that tonight he is "on".)

Sue Bullwinkle

Faculty Meeting

photographs by
david lawlor



"Tea will be served at 4:00 p.m."



"I. Appointments—Medical School and School of Dental Medicine."



"II. Predicted needs of the armed services for physicians."



"III. Plans for the Warren Museum–Dr. Yakovlev. . . ."



". . . . with particular reference to the neurological sciences–Dr. Adams."



"IV. Medical T.V. and advertising–Dr. Berry."



Unscheduled items . . .

the facts about "The Facts of Medicine"

Parker Wheatley
GENERAL MANAGER
WGBH-FM AND WGBH-TV



Dr. David D. Rutstein, Professor of Preventive Medicine at Harvard Medical School, and Dr. Parker Wheatley, General Manager of WGBH-TV and FM, before Channel 2 television cameras on *The Facts of Medicine.*

"The Facts of Medicine," which has just completed six months on WGBH-TV, Channel 2, Boston, really began in 1949 with the radio series "A Long Life" over Station WCOP. The Lowell Institute Cooperative Broadcasting Council presented the 33 programs in the 1949 series under the supervision of a committee appointed by the then deans of the medical schools of Boston University, Harvard and Tufts, the Doctors Faulkner, Burwell and O'Hara. The committee members, Dr. William L. Fleming, Boston University School of Medicine, Dr. David D. Rutstein, Harvard Medical School and Dean O'Hara himself of Tufts Medical School, met with members of the Council staff and me to devise a plan and select subjects. The plan was to inform a general adult audience about the principal diseases, their prevention and treatment. The participants were to be outstanding authorities in the particular subjects and, whenever possible, persons who had experienced the disease. This early experiment in weekly medical broadcasts by Greater Boston's medical schools was judged responsible and successful, at least to a degree which encouraged further medical broadcasting.

The next major effort occurred in 1954 at the time the association between cigarette smoking and lung cancer became a national concern. By then, the Lowell Institute Cooperative Broadcasting Council had established its own educational frequency modulation station, WGBH-FM. Dr. Rutstein was consulted and agreed to undertake an hour long conversation entitled "Smoking and Lung Cancer." The initial broadcast of January 15 was repeated on January 16 and March 3, and a revised broadcast presented on August 24 following the release of additional data.

The growth of WGBH-FM had stimulated the Council to plan a television station. Thus in 1954, during the building and program planning stage for WGBH-TV, Channel 2, the John Hancock Mutual Life Insurance Company expressed to the Lowell Institute an interest in contributing to the programming of the new educational station. Two alternatives were offered for a series of programs which John Hancock might consider supporting with a grant-in-aid. The alternative which most interested the prospective donor was "The Facts of Medicine," with Dr. David D. Rutstein, Professor of Preventive Medicine and Head of the Department at the Harvard Medical School. This was the first step in a series of negotiations which resulted in a grant of $44,550 to be divided equally between the Lowell Institute for producing the programs in the studios of WGBH-TV and for staff expenses required by Dr. Rutstein to prepare the programs.

Dr. Rutstein was to be solely responsible for the content of the programs and all parties were to be able to call attention to them by publicity and promotion, provided all agreed upon material to be released. The plan was for forty broadcasts over a period of 39 weeks. All subjects were to be chosen by Dr. Rutstein. The agreement also provided that I collaborate with him in the preparation and production of the programs and actually participate in the broadcasts on WGBH-TV.

President Pusey and Dean Berry, in turn, made public statements for the press about the new medical series

and it was inaugurated Thursday night, October 6, at 8:30 o'clock, with the subject "Polio Vaccine." The broadcast was announced as "the first of forty programs to help you prevent disease and protect your health and that of your family." The subject was selected as appropriate to the season and of common concern. Although not a news program, subjects appropriate to the season and events have been selected. The most compelling criterion has been that each broadcast actually presents all relevant facts insofar as possible in a thirty minute period and in a communication directed to the lay audience. There has been no talking down to viewers, even though they have been thought of as laymen. Simplicity, informality, and a conversational quality of address have been sought for as appropriate to the purpose of the series and the medium. My own participation with Dr. Rutstein has, I trust, enabled him better to conceive of members of his unseen audience as alternately I have listened, asked questions and sought clarification.

Many physicians and medical workers are becoming increasingly familiar with television broadcasting but a look at what is involved in presenting "The Facts of Medicine" may be particularly interesting. The selection of subjects, of course, is the prime consideration. Some are scheduled many months in advance, while others are chosen as late as five days before their actual broadcast. Viewers have been invited to send in suggestions for subjects and a conscientious effort has been made to present those subjects which most viewers have requested. Among these have been topics which Dr. Rutstein originally had planned to include in the series. At this writing some 70 subjects have been suggested and 12 of the 24 already broadcast have been requested by viewers.

The sequence of preparation for a program begins immediately at the end of any particular broadcast at 9:00 o'clock Thursday night. Then Dr. Rutstein, Mr. Peter Hollander, our photographer, and I begin discussion of film for the program two weeks hence. This may be a short informal meeting. Friday is a relatively "free" day for Dr. Rutstein, insofar as preparation for broadcasts is concerned, but Mrs. Marjorie Taubenhaus, his research assistant, will have begun a review of the medical literature for the next program. Not infrequently, Dr. Rutstein and I have a meeting that evening in his home, or have a long telephone conversation.

Our first meeting on a subject may or may not result in the preliminary outline. In any case, he and I develop a general plan for further thinking and study over the week-end, and may even meet for another conference Saturday or Sunday. Monday, or at the latest Tuesday, another meeting is required to conclude what approximates a final outline. This outline must include the plan of the broadcast, data Dr. Rutstein will present and accompanying visual materials. A member of his department, Miss Katharine Hendrie, will have been assigned charts to prepare and Mrs. Taubenhaus, having

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completed a preliminary survey of the medical literature, will check information and references on special points of desired material, assisted by Mrs. Marion Lent, program secretary. Mrs. Eunice Ward, program secretary of my staff, meanwhile, will have been collecting various data and materials for my use. Mr. Hollander will have taken the scenes for the motion picture insert in the program and the film will be in the process of development. If the program is to use excerpts from films already made, Mr. Hollander will be at work editing the various segments into the appropriate single unit or units Dr. Rutstein will present during the broadcast on Thursday night.

There is likely to be a conference at WGBH-TV on Wednesday in which we check the charts and other visual materials for the next day's broadcast. If the kinescope of a previously recorded program has arrived from the New York film laboratory, we will screen this to see what can be learned for the next broadcast. Thus, in addition to preparing for from one to two broadcasts concurrently, we also study past broadcasts. In the background of all these conferences and preparation is Mr. Paul Rader, WGBH-TV Director of Production, and Director of "The Facts of Medicine," who is consulted on the program plan, on the technical appropriateness of visual material, proper staging and presentation by Dr. Rutstein and myself on the air.

What cannot be accounted for is the time required by Dr. Rutstein for supervision of others, analysis and study of necessary data for each subject, talking with authorities throughout the country and the vast amount of reading necessary to assure himself that all recent works on a particular subject are included in the preparation. At least half of a normal working week for a Harvard professor is required in his preparation. Dr. Rutstein conducts the programs as part of his regular tasks in the Medical School.

Thursday afternoon at 3:30 there is a technical rehearsal of the program of that evening in which the visual materials are put on camera, film inserts projected, and all technical preparations completed. At this time, last minute checks on the placement of lights are made. The set, a replica of a corner of Dr. Rutstein's office in Building D #1 at the Medical School, also is put in order. A further conference usually follows and there is barely time for Dr. Rutstein and myself to have a short dinner and return for the broadcast at 8:30. We meet for final review before the program begins. There is no manuscript, only an outline. The entire program is presented *ad libitum.*

The broadcast requires the services of 2 cameramen, a floor manager, an audio and a television engineer, a projectionist, 2 additional engineers (if a kinescope recording is being made), an engineer at the WGBH-TV transmitter, Mr. Rader and our announcer, Mr. William Pierce, in addition to Dr. Rutstein and me. Back of us have been the station's stage manager and his assistant and a lighting technician. This staff, however, is small indeed compared to the large number of persons required for commercial medical programs.

What Dr. Rutstein says and does, and how he looks and sounds is being witnessed not only by an unknown number of persons from among the 1,400,000 television homes within range of WGBH-TV, Channel 2, but by his professional colleagues. Furthermore, he is aware that a completely unestimated number of general viewers and professional colleagues throughout the United States may also hear him when the kinescope recordings of 13 of his 40 broadcasts will be distributed on more than 20 educational television stations beginning late Summer or early Fall.

In the past six of the total of nine months of the series, just under 1000 letters and cards have been received from 206 cities and towns in New England. Some have asked questions, some have suggested subjects and others simply have written to express appreciation for what they have been seeing and hearing from week to week. These viewers have ranged widely in their social, educational and economic status. One viewer has written, "It is a fine and even superb program, for the following reasons: Dr. Rutstein's competence, style and ease, the reticence of the interviewer, the welcome absence of distractive movements, props and 'gimmicks,' the subjects and content." Most letters have commented on the integrity of "The Facts of Medicine" broadcasts. In a period of sensational treatment of medical themes, this response is most encouraging. Dr. Rutstein personally responds to all letters and cards concerning the program.

A very great need exists for a systematic study of viewing of these broadcasts and their value to observers. It would seem to be a matter of direct concern of medical schools and of the medical profession itself to have reliable information on public response to medical broadcasting such as Dr. Rutstein has conducted, especially in contradistinction to many of the performances now presented on television. Only scientific audience research in connection with such experiments as "The Facts of Medicine" can provide reliable data. Certainly an extraordinary opportunity exists in this present series and in the facilities of WGBH-TV, as a non-commercial educational station on Channel 2 in Boston, to provide for continuing experiment and study of the relationship between medicine and the public.

Editor's note: Mr. Wheatley modestly fails to make clear that he is an active participant and collaborator with Dr. Rutstein, both in the preparation of material and in front of the cameras.

Medical Education in the Community Hospital

John F. Stapleton, M. D.
DIRECTOR OF MEDICAL EDUCATION, ST. VINCENT HOSPITAL, WORCESTER, MASSACHUSETTS

The years since World War II have witnessed a notable increase in graduate training opportunity for young physicians. Indeed, the number of available residencies and fellowships has far outstripped the number of candidates so that only a relatively few traditionally prized appointments remain highly competitive. Most of this educational expansion has occurred in the country's many university medical centers or in government service installations associated with these centers. As a result, most of the country's interns and residents have become concentrated in areas surrounding medical schools. Non-university community hospitals have noted a steadily declining interest in their house officer appointments. Lacking the educational resources of the schools and the financial resources of the government, these hospitals have been at a disadvantage in the more or less frank competition that has developed for house officers. Many community hospitals are unable to fill their intern quota with graduates of approved schools. Some have attempted to fill the gaps with foreign graduates, others have simply functioned without a house staff. This situation unfortunately deprives community hospital patients of the undeniable advantage in medical care provided by an effective house staff.

Recently a number of larger non-university community hospitals have undertaken major revisions of their graduate training programs. These revisions have included some or all of the following: full-time director of medical education; guest physician schedule; medical school affiliation. The objective: to stimulate interest of recent graduates in community hospital house officer appointments and to provide a source of continuing education for staff physicians. Of course the long term objective, as with all medical education, is improved patient care.

The position of full-time director of medical education has now been established in many community hospitals. In most instances the director is an internist; more recently some hospitals have added a part-time director of surgical education. The multiplicity of details involved in the operation of a well balanced teaching plan are best handled by such a director, at least in the larger institution. While he may do considerable teaching himself, his main role is that of organizer and coordinator. Many directors are young men who have recently completed their own training; this proximity of age and education favors a good relationship with interns and residents. In fact the mere presence of an educational director reassures the house officer that his educational needs are being seriously regarded. Most directors do not engage in private practice, although there is local variation in this regard. In some instances the director, with appropriate background, may bring to his hospital special technical knowledge in fields such as hematology, radioactive isotopes or endocrinology which were not previously represented on the attending staff. He may engage in clinical investigation.

Many non-university hospitals have incorporated a guest physician schedule in their programs, with or without definite medical school association. The visiting teacher and school affiliation features of a program inaugurated recently at the St. Vincent Hospital of Worcester, Massachusetts, will be discussed in some detail as this program may typify a trend. The affiliated school in this instance is the Georgetown University School of Medicine of Washington, D.C. Although at first glance, affiliation with a school five hundred miles away would appear cumbersome, the feasibility of this arrangement has been borne out by the experience of St. Mary's Hospital of Rochester, New York, and the Mercy Hospital of Buffalo, New York, who have been associated with Georgetown for five years.[1] The affiliation provides a number of qualified teachers chosen from the medical school faculty who visit the hospital and serve as professors *pro tempore* for two or three day periods. During this time the guest physician conducts bedside rounds, presides over conferences, gives a formal lecture and usually discusses a case summary at a clinicopathological conference. He is provided quarters in the hospital and often has the opportunity to sound out interns and residents on the ups and downs of the house officership. Many times he is

entertained socially by attending physicians; fruitful exchanges of ideas often occur in the relaxing environment provided on such occasions.

In addition to the "*pro tempore*" type of visit paid by the school faculty members, a number of shorter sessions have been conducted by teachers from nearby medical centers. Physicians from the three Boston medical schools have graciously given their time to participate in this project. The Boston teachers usually spend a morning or, at times, a whole day.

Two points deserve special emphasis in connection with the guest physician program. First, the purpose of the visiting teacher is to supplement rather than substitute for instruction offered by the attending staff physicians. Second, the visiting schedule is not a lecture series; most of the teaching is of the bedside variety with didactic instruction minimized.

During the first year of affiliation, over one hundred and fifty patients were seen by guest instructors. Most have been private patients. However, there has been no problem in utilizing private patients as "teaching cases"; both the patients and their doctors have been most cooperative. Moreover, the attending physicians have not encountered any noticeable decline in consultations which could be attributed to the "competition" of guest physicians. Actually, most patients presented have already been examined by an attending physician at the consulting level. The use of private patients in teaching has become common practice in most teaching hospitals, both university and non-university. Ward services have tended to become weighted in favor of the degenerative diseases seen in older patients. Private services, on the other hand, provide a cross section of disease as it exists in the younger, productive age groups who are more often able to afford private care. It is important to emphasize that house officers assigned to private services are allowed considerable supervised responsibility. Actually, the relationship of patient to house officer to attending physician should not be too far removed from that which exists on a properly supervised ward service. The special problem raised by application of this principle to surgical procedures is beyond the scope of this discussion.

Obtaining an educational director and university assistance does not assure a successful program. Recent graduates tend to regard non-university hospital programs with some misgivings. Some of the reasons for this skepticism: failure of a given hospital to attract house officers in previous years; the shrinking ward service in many non-university hospitals; failure of some hospitals in the past to subordinate service needs to educational requirements; lack of prestige attached to house officer appointments in hospitals not widely known. These and other doubts will only be satisfactorily answered when the community hospital has acquired a backlog of satisfied house officers who will vouch for the value of the program offered. Acquisition of such a group is a difficult hurdle for most non-university hospitals and may be an impossibility for some.

Another set of problems has involved the status of the director of medical education. As a full time salaried employee of the hospital without private practice, he has a more or less unique position on the staff. A delicate relationship exists between himself and the practicing physicians. Breakdown of this relationship has resulted in discontinuance of the position in several institutions. Most of the frictions which have developed can be traced to inadequate advance understanding and agreement by all concerned on the scope of the director's authority and responsibility. Some institutions who acquired directors did so at a time when few precedents had been established so that problems inevitably rose which had not been foreseen. One source of contention has been the matter of competition with attending physicians. This is especially pertinent when the director engages in private practice. Another major sore point can develop if the director drifts into the role of administrative official. Physicians will always resist assumption of staff prerogatives by a representative of the administration, albeit a physician. On the other hand, the staff must be willing to make whatever alterations are necessary to meet the rising standards of education even though at times these changes will entail sacrifices in time and convenience. If a program is established without clear-cut staff understanding on this point, friction is bound to develop. Some problems have arisen because of the personalities involved. The St. Vincent directorship was set up with knowledge of these and other pitfalls. Since all parties concerned were amply consulted in advance, the director has, thus far, experienced minimal frictions and antagonisms.

Needless to say, day-to-day contact with attending physicians on the wards remains the major source of the house officers' educational experience. Effective education in the community hospital will always depend on the active interest and participation of the attending staff. On the other hand, the physician who is teaching and conducting research in a medical center often can contribute basic science correlation as well as new information in his own field. Instruction of this type at the community hospital bedside would seem highly desirable, and in actual practice has been well received by the attending as well as house staff. Blending these two sources of education promises to be a fruitful combination of teaching styles.

Medical school affiliation also provides professional advice on teaching techniques, necessary alterations of facilities and other matters involved with the mechanics of an educational program. In addition, consultation is available on problems not strictly educational, such as setting up radioactive isotope facilities or introducing new clinical laboratory procedures.

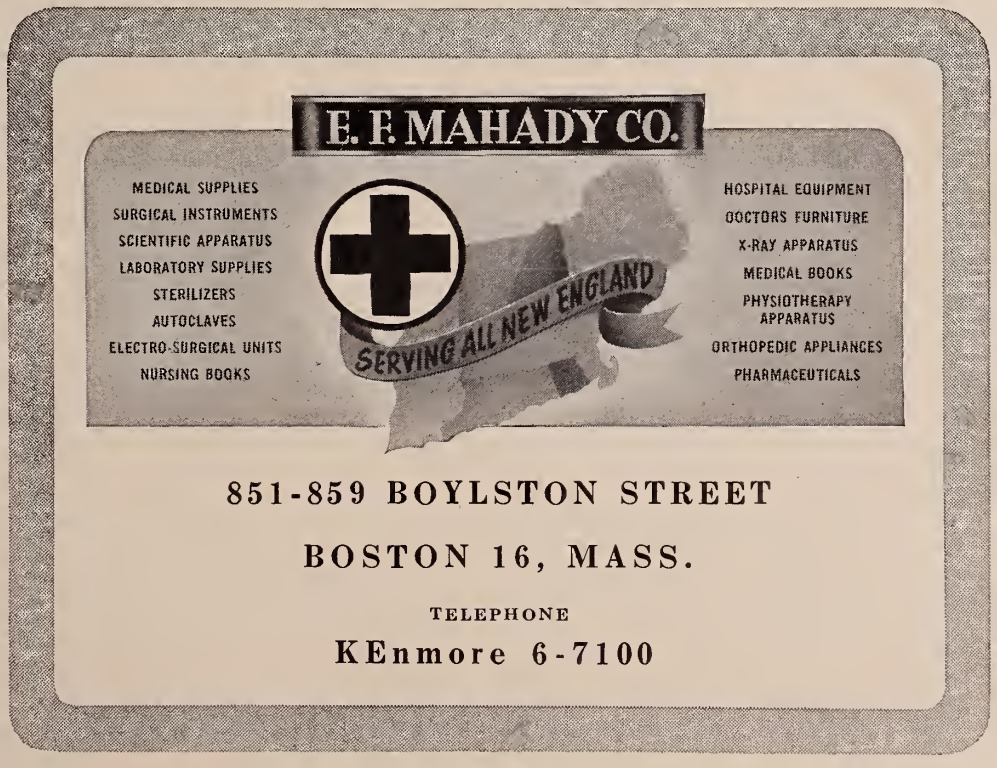
A university center can contrib-

ute significantly to community hospital residency programs by making available periods of service at the center. This must be done by prearrangement so that the resident actively participates rather than passively observes. The St. Vincent plan calls for rotation of a medical resident through the rotating "basic science" residency at the medical center each year. This includes assignments to the infectious disease, hematology, metabolic and other comparable services. Similarly, a surgical resident may serve up to six months at the university hospital with assignment to anatomy, pathology, experimental laboratory or clinical surgery depending on individual needs and preferences. Obviously, this exposure would be ineffective if the resident simply watched proceedings from the observer's circle. Arrangement must be made in advance to incorporate the house officer into the university's program so that he plays an active role comparable to that of the medical center's own residents.

Clearly, expanded community hospital educational programs will not solve the house officer shortage. At best, a shift of house officers to the larger community hospitals conducting these programs may occur but the numerical gap between graduates and appointments will remain unchanged. It is unlikely that many smaller community hospitals (200 beds or less) could attract house officers with a program of this type. The attending staff must carry on the important day-to-day bedside teaching in any program. The smaller hospital often lacks a sufficient complement of qualified instructors in all the major fields to offer well balanced graduate training. How to supply patients in small community hospitals with the valuable service of a house staff without sacrificing educational standards remains a problem.

An important by-product of programs of the type described is the continuing education of the community hospital attending staff. The constant deluge of new medical information and the difficulties in keeping abreast are well known to doctors in all fields. Any plan which affords educational opportunity in the doctors' own backyard is bound to benefit the busy practitioner and, in the long run, his patients. The guest physicians actually provide a continuous postgraduate course in the community hospital; indeed many of the teaching visitors are doctors who participate in more formal postgraduate courses sponsored by various organizations. More important perhaps than contact with visiting instructors is the stimulus provided by teaching. It is common pedagogical experience that the teacher learns more than the pupil. One is hard put to conceive of better postgraduate education than that provided by exposure to the enthusiasm of young doctors in training. This aspect of the program may well turn out to be a more important contribution in the field of medical education than improved house officer training *per se*.

[1] Jeghers, H., O'Brien, J., and Butler, J. An experiment in making the hospital a graduate medical center—A preliminary Report. *J.A.M.A.* 158, 245.



Bats in the News

Lamar Soutter, '35



Official photograph, U. S. Navy

Alvin Novick, '51, and friend

Recently articles have appeared in the *Philippine Press* concerning a research project on bats being conducted under the direction of Alvin Novick, '51. Dr. Novick, an internist, is presently a Research Fellow in Biology at Harvard. Under the joint sponsorship of Harvard, the Office of Naval Research and the U. S. Public Health Service, he is collecting bats in Ceylon, the Belgian Congo and the Philippines, for the purpose of studying their method of crepuscular guidance by the emission of high pitched sounds. Most bats, particularly those which feed on flying insects, have poor eyesight and are dependent upon the echoes of the sounds which they emit (at a rate of about 200 per second and at a pitch way above what we can hear) for information as to what lies in their paths as they fly. For this purpose their ears are large and very effective. Bats vary tremendously in size, shape, color and habit, their variations being dependent almost entirely upon their diet and the adaptations necessary for obtaining it. The fruit eating bats which Dr. Novick has recently collected in the mountains of the Philippines, often have quite good eyesight and their ability to guide themselves by sound is either primitive or lacking altogether, whereas the insect-eating ones have this form of guidance highly developed. Methods of study include both anatomical dissection of dead specimens and the recording of sounds made by captured live ones. Under either circumstances the bats are not easy to obtain. In the mountainous Zambales Jungle, they sleep in the daytime hanging inverted in the tops of trees many feet above the ground. Netting them is almost impossible as they usually are awakened by anyone climbing the trees in which they hang. When disturbed they often fly at a great height, out of shotgun range, above the trees. Those which have been shot have been eaten by the natives as a rare delicacy. Members of the expedition have found the meat to be tasty but the local methods of preparation unhygienic and highly objectionable. The method employed by Dr. Novick's natives for capturing the bats is quite ingenious—trees employed regularly as bat-roosts are sawed most of the way through at night when their tenants are absent. On the following day the cuts are completed and the trees fall bringing down their colonies to earth. Once upon the ground the bats are easy to capture as their legs are too short to permit rapid locomotion and they must depend for the initiation of flight upon plummeting from a high perch. Once netted and captured, Dr. Novick's problem of obtaining the cooperation of his bats has just begun. Not only will many of them not eat in captivity but they die readily (particularly the tropical ones) if exposed to much change of temperature. Furthermore, most bats have unpleasant dispositions to say the least and many are downright nasty. If Dr. Novick is able to enlist their help in "sonar" studies for the benefit of the Navy, he is doing well. From our experiences with New England bats he is apt to find them about as friendly and cooperative as a Soviet Satellite.

The capture of bats in this part of the world is a very different matter. The bats roost in clusters under the eaves of houses or camps. Owing to their deplorable bathroom habits their presence above is readily apparent because of a heap of spoor on the floor beneath. Armed with a long stick and a fish net, they can be easily

captured with little risk of anything more than having a finger or two chewed to ribbons when one tries to extricate them from the net. The terror some people have that a bat in flight will strike or bite them is quite unfounded. By using their "sonar," under study by Dr. Novick, they can swoop quite close to a human head without touching it. Anyone who takes his girl for an evening paddle on the upper reaches of the Charles, can reassure her that unless a large number of succulent insects abound in her coiffure, she will be untouched by the little fellows. Once captured, bats need plenty of room in which to move about. On close study one can readily observe how savage they really are. Some, like the giant fruit-bats of the Philippines, have long straight noses giving them a slightly canine appearance from whence they derive the name of "flying fox." Those currently collected by Dr. Novick are gigantic, measuring over four feet from wing tip to wing tip. They are not the largest, however, some in Java having a wingspread of five feet. These fruit bats have only a moderately mean expression when captured,—they are probably mollified by their diet of sweet fruit. Not so their New England insectivorous cousins. Their faces are absolutely vicious no matter how great is the tender loving care lavished upon them by their captors. Ours are by no means the worst. The meanest looker of all is the Javelin nosed Vampire bat of South America which combines with its consummate ferocity of expression a sharp spike tilted upward on the end of its nose. Captured bats in this part of the world are disinterested in dead insects furnished them as items of diet. They will occasionally eat raw kidney if the area of their incarceration is large enough to give them the illusion that they are free. Most bats subsist on varied diets to some extent. Not all of the fruit bats just eat fruit, some eat insects and some have adapted themselves also to live on pollen. Only one genus (Desmodus) of the vampire bats subsists entirely on a diet of blood. It is of some interest to note that the facies, teeth, claws and tongues of various species, are modified to suit their dietary habits. The fruit eaters have a longer intestine and have spinous processes beyond the third cervical which are missing in the others. The vampires have further internal modifications, their esophagi are narrowed and the cardiac end of their stomachs has become elongated so as to form an almost separate appendage.

The appearance of our bats is made more depressing because of their dirty grey color which makes them look as drab as a downtown building. Elsewhere in the world bats are of more varied hues. Some that Dr. Novick is dealing with are buff or brown. In other places, particularly in tropical Africa there are light colored ones. The Lava Frons is a bright greenish grey with yellow wings. T. Mauritianius is a pale buff overlaid with a wavy pattern of silver and black. One of the vampires has a brown body and black wings trimmed with white. Another bat has red wings, splashed with black. Other colors than mousey grey are seen in New England, too. Once when sailing in the Gulf of Maine we were startled to see a small peach colored bat come fluttering out of the fog. For the next few hours it stayed with us, flying off now and then, but always returning. Apparently it was reluctant to cling to the rigging which so little resembled a tree yet it was reluctant to leave the boat which so much resembled land. Eventually, when the distant roar of breakers announced the nearness of the Libbey Islands it departed in vague intemperate flight towards the sound and was lost in the mist.

The hostility of bats toward humans stems from their savage, quarrelsome dispositions. If their expressions give a fair indication of their nature, they must be constantly seething inwardly with molten anger. Although they congregate in large tree top colonies in the jungles, they are incessantly fighting among themselves. Their return to roost at daylight is marked by a hubbub of angry cries and continual bickering until eventually the colony falls asleep. They have other human attributes besides their gregariousness and tendency to quarrel: they possess but two mammae and they conceive but one offspring at a time. The difficulty of the female flying with more than one baby bat clinging to the soft fur of her abdomen is easy to imagine.

It would be interesting to see if in the course of his travels, Dr. Novick is able to find a mild-mannered fruit-eating tropical bat which will condescend to fraternize with him and his co-workers so that the functioning of its "sonar" may be studied. Perhaps it will be the Indian bat which lives on Mowhooa berries. Certainly our vicious little domestic bat would not cooperate with any research project no matter who sponsored it. When kept in close confinement any apparent abatement of its ferocity is only due to the asthenia resulting from its self-imposed starvation. The day that the bat lover finds that the little beast will permit itself to be patted is the day it has become too weak to bite and is usually its last day. There is a method of prolonged preservation of our bats in captivity. If when captured, the bat is placed in a refrigerator he will, after a few preliminary displays of temper, go to sleep. This enforced hibernation may be maintained up to six months. At the end of this period the bat must be removed from the Frigidaire and allowed to warm up. Just before he awakens he shivers all over and emits a high pitched hum not unlike a miniature DC-8 revving up. When fully awake, he will drink a little water and then may be replaced in the refrigerator for another six months. Although animal lovers who delight in intimate daily association with their pets may not care for this method of bat preservation, it has many advantages. The bat becomes economical to feed, does not require to be house broken, and most important of all, has a prolonged period of tranquility seldom enjoyed by these unlovable little creatures.

INTERNSHIPS.

CLASS OF 1956

photographs by

Francis Curley



Unless otherwise noted all *internships* start July 1, 1956 for one year.

Name	*Hospital (and location)*	*Service*
Adimora, Nwanneka		
Adler, Anita	Strong Memorial, Rochester, N. Y.	Pathology
Alper, Chester A.	Boston City (Harvard Service)	Medicine
Alpert, Joel J.	Children's Medical Center, Boston	Pediatrics
Amick, Arthur F.	Massachusetts General, Boston	Medicine
Anderson, W. Banks, Jr.	Duke, Durham, N. C.	Surgery
Arrington, Thomas H.	University, Jackson, Miss.	Rotating
Baden, Howard P.	Peter Bent Brigham, Boston	Medicine
Baker, Lawrence	Beth Israel, Boston	Medicine
Ball, Mary V.	Mary Hitchcock Memorial, Hanover, N. H.	Rotating
Barbarisi, Charles F.	Boston City (Harvard Service)	Surgery
Barnett, G. Octo	Peter Bent Brigham, Boston	Medicine
Baumgartner, Donavin A., Jr.	University Hospitals, Cleveland, Ohio	Surgery
Bergel, Ernest W.	North Carolina Memorial, Chapel Hill	Medicine
Bergin, William F.	Veterans Administration, Los Angeles, Calif.	Rotating
Border, John R.	U.S. Public Health, Brighton, Mass.	Mixed
Branch, Benjamin N.	Mary Hitchcock Memorial, Hanover, N. H.	Rotating
Brochin, Malcolm	Roosevelt, New York City	Mixed
Brown, Norman K.	Massachusetts General, Boston	Medicine
Bryant, Kirby K.	U. of Texas Medical Branch Hosps., Galveston	Rotating
Bullwinkel, Bob	Massachusetts General, Boston	Surgery
Bush, William G.	Boston City (Harvard Service)	Medicine
Cameron, Alan B.	University Hospitals, Columbus, Ohio	Rotating
Caner, John E. Z.	King County, Seattle, Wash.	Medicine
Chamberlin, Robert W., Jr.	Mary Hitchcock Memorial, Hanover, N. H.	Rotating
Ciccarelli, Eugene C.	Peter Bent Brigham, Boston	Medicine
Claflin, Robert	Herrick Memorial, Berkeley, Calif.	Rotating
Clendenin, Thomas M.	Mary Imogene Bassett, Cooperstown, N. Y.	Mixed
Clubb, Robert W.	U.S. Public Health, Brighton, Mass.	Mixed
Cockrell, Wayne P.	University, Jackson, Miss.	Rotating
Coggeshall, Richard E.	Cook County, Chicago, Ill.	Rotating
Cookson, David U.	Ancker, St. Paul, Minn.	Rotating
Cotsen, Robert S.	Boston City (Harvard Service)	Medicine
Davis, John S.	Mary Imogene Bassett, Cooperstown, N. Y.	Medicine
Dennis, LeBaron W.	Mary Hitchcock Memorial, Hanover, N. H.	Rotating
Dorr, Andrew D.	Boston City (Tufts Service)	Medicine
Dunn, Frederick L.	King County, Seattle, Wash.	Rotating
Edmunds, Louis H., Jr.	Massachusetts General, Boston	Surgery
Eisenberg, Myron M.	Peter Bent Brigham, Boston	Surgery
Fallon, Richard H.	Barnes, St. Louis, Mo.	Surgery
Fleming, T. Corwin	U. of California Hospital at Los Angeles	Medicine
Franklin, Stanley S.	New York, New York City	Medicine

Name	*Hospital (and location)*	*Service*
Freedberg, Irwin M.	Beth Israel, Boston	Medicine
Gallo, Anthony E.	Boston City (Tufts Service)	Surgery
Garren, Leonard	Duke, Durham, N. C.	Medicine
Gilmore, Bruce L.	New York, New York City	Medicine
Goldberg, Leon I.	Massachusetts General, Boston	Medicine
Goldstein, Stanley	Bellevue (III Div.-N.Y.U.), New York City	Pediatrics
Goldwyn, Robert M.	Peter Bent Brigham, Boston	Surgery
Goodell, Robert A., Jr.	Hartford, Hartford, Conn.	Rotating
Goodman, Allen D.	Peter Bent Brigham, Boston	Medicine
Gordon, Spencer, Jr.	Johns Hopkins, Baltimore, Md.	Surgery
Greenberg, Jack J.	Massachusetts General, Boston	Surgery
Greenberg, Nathaniel	U. of Chicago Clinics	Rotating
Grover, John W.	Massachusetts General, Boston	Surgery
Haggett, Everett W.	Mary Hitchcock Memorial, Hanover, N. H.	Rotating
Hall, William A.	Boston City (Boston U. Service)	Medicine
Hansen, Marc F.	Boston City (Harvard Service)	Medicine
Hardenbergh, Firmon E.	Pennsylvania, Philadelphia	Rotating
Harris, Eddie H.	Kings County, Brooklyn, N. Y.	Rotating
Henshaw, Edgar C.	Boston City (Harvard Service)	Medicine
Hickok, David F.	Peter Bent Brigham, Boston	Surgery
Higgins, Ernest A., Jr.	Boston City (Harvard Service)	Medicine
Hitselberger, William E.	U. of Minnesota Hospitals, Minneapolis	Surgery
Hochman, Raymond B.	Beth Israel, Boston	Medicine
Hunt, Thomas K.	Boston City (Harvard Service)	Surgery
Iseri, Oscar A.	King County, Seattle, Wash.	Medicine
Jacobey, John A., Jr.	Jefferson Davis, Houston, Texas	Surgery
Jick, Hershel	Beth Israel, Boston	Medicine
Katz, Arnold M.	Massachusetts General, Boston	Medicine
Kaufman, Herbert E.	Massachusetts General, Boston	Medicine
Kaupe, Walter		
Kellogg, Donald A.	North Carolina Memorial, Chapel Hill	Medicine
King, Leonard E.	U. of California, San Francisco	Surgery
Kisch, Alex L.	Duke, Durham, N. C.	Medicine
Korndorffer, William E., Jr.	Jefferson Davis, Houston, Texas	Rotating
Lafferty, Frederic W.	U.S. Army, Walter Reed, Washington, D. C.	Rotating
Laws, Henry L., 2d	Jefferson Davis, Houston, Texas	Rotating
Lederman, Melvin	U. of California, San Francisco	Surgery







Name	*Hospital (and location)*	*Service*
Leonard, Lawrence M.	Beth Israel, Boston	Surgery
L'Esperance, Francis A., Jr.	Presbyterian, New York City	Surgery
Levine, Norman D.	Mount Sinai, New York City	Rotating
Liang, Edward Y.	Bellevue (III Div.-N.Y.U.), New York City	Medicine
Lobpreis, Ervin L.	U. of California Hosp. at Los Angeles	Surgery
MacLeod, Gordon C.	U.S. Air Force, Madigan Army, Tacoma, Wash.	Rotating
Marcello, David E., Jr.	Beth Israel, Boston	Surgery
McArthur, James R.	Salt Lake County General	Medicine
McHugh, Paul R.	Peter Bent Brigham, Boston	Medicine
McKee, Donald M.	Massachusetts General, Boston	Surgery
McRae, John M., Jr.	University, Jackson, Miss.	Rotating
Menno, Albert D.	Edward J. Meyer Memorial, Buffalo, N. Y.	Rotating
Messer, Joseph V.	Boston City (Harvard Service)	Medicine
Miller, Alfred E.	Massachusetts General, Boston	Surgery
Miller, Lee G.	North Carolina Memorial, Chapel Hill	Mixed
Milne, John H.	Pennsylvania, Philadelphia	Rotating
Monaco, Anthony P.	Massachusetts General, Boston	Surgery
Moore, Thomas E., Jr.	Jefferson Davis, Houston, Texas	Surgery
Moss, Malcolm H.	Mary Hitchcock Memorial, Hanover, N. H.	Rotating
Muhich, Donald F.	Ancker, St. Paul, Minn.	Rotating
Nevison, Thomas O., Jr.	U. of Oregon Medical School Hosps. and Clinics, Portland	Rotating
Norton, Charles E.	U. of Illinois Research and Educational, Chicago	Rotating
Norton, Robert E. G.	Iowa Methodist, Des Moines	Rotating
O'Hara, Richard S.	University Hospitals, Cleveland, Ohio	Surgery
O'Malley, Joseph P.	U.S. Public Health, Brighton, Mass.	Mixed
Pahnke, Walter N.	Denver General	Rotating
Parks, William S.	U. of California, San Francisco	Rotating
Parshley, Philip F., Jr.	Boston City (Harvard Service)	Surgery
Paul, Geoffrey R.	U. of California, San Francisco	Medicine
Perlmutter, Alan D.	Peter Bent Brigham, Boston	Surgery
Perry, Ralph E., Jr.	Bellevue (III Div.-N.Y.U.), New York City	Pediatrics
Peterson, Chase N.	Grace-New Haven Community	Medicine
Powell, Malcolm R.	U.S. Naval, Oakland, Calif.	Rotating
Radding, Charles M.	Boston City (Harvard Service)	Medicine
Raitt, James W.	U. of Kansas Medical Center, Kansas City	Mixed

Name	*Hospital (and location)*	*Service*
Reich, Peter	Peter Bent Brigham, Boston	Medicine
Rohde, Russell A.	Los Angeles County	Rotating
Rose, James A.	Massachusetts General, Boston	Medicine
Rosen, Saul W.	U. of California, San Francisco	Medicine
Rosenberg, Murray D.	Beth Israel, Boston	Medicine
Ross, John J.	Cleveland City	Rotating
Roth, Sanford I.	Massachusetts General, Boston	Pathology
Ryan, James H., Jr.	U. of California, San Francisco	Medicine
Sabath, Leon D.	Peter Bent Brigham, Boston	Medicine
Saidi, Parvin (Miss)	U. of California Hospital at Los Angeles	Medicine
Schatzki, Stefan C.	Boston City (Harvard Service)	Medicine
Schwob, Marianne F. (Miss)	Bellevue (III Div.-N.Y.U.)	Pediatrics
Sell, Kenneth W.	U.S. Navy, Bethesda, Md.	Rotating
Shafron, Melvin	University, Ann Arbor, Mich.	Rotating
Smith, Gardner W.	Johns Hopkins, Baltimore, Md.	Surgery
Snow, James B., Jr.	Johns Hopkins, Baltimore, Md.	Surgery
Sogg, Richard L.	Cleveland City	Rotating
Spencer, E. Martin	San Francisco (U. of California Service)	Rotating
Spillane, John J. B.	Cleveland City	Rotating
Steinhardt, Rosalind (Miss)	New England Center, Boston	Medicine
Stell, Robert B.	Barnes, St. Louis, Mo.	Surgery
Sterling, Roger A.	Veterans Administration, Los Angeles, Calif.	Rotating
Stiles, Claire M. (Mrs.)	Postponed	
Strickler, William L.	Barnes, St. Louis, Mo.	Surgery
Stroud, Robert M.	Cook County, Chicago, Ill.	Rotating
Svoboda, Donald J.	U. of Kansas Medical Center, Kansas City	Pathology
Taira, Tom K.	University Hospitals, Columbus, Ohio	Rotating
Tashima, Charles K.	Bellevue (II Div.-Cornell), New York City	Medicine
Thamer, Mahmud A.	Baltimore City Hospitals	Rotating
Tucker, George L.	Barnes, St. Louis, Mo.	Surgery
Vine, Bernard G.	Jefferson Davis, Houston, Texas	Surgery
von Hippel, Josephine B. R. (Mrs.)	George Washington U., Washington, D. C.	Rotating
Walker, Jerome K.	V.A. Hospital, Boston	Surgery
Weinberg, Arnold N.	Massachusetts General, Boston	Medicine
White, Martin K.	Children's Medical Center, Boston	Pediatrics
Young, Charles W.	Bellevue (II Div.-Cornell), New York City	Medicine
Zehner, Harry, Jr.	U. of California, San Francisco	Surgery



HONORS



Dr. Fulton

John F. Fulton '27, Sterling Professor of the History of Medicine at Yale, was honored by more than 100 of his former students and colleagues at a reception on January 15, 1956. Highlight of the reception honoring his 25 years of service to Yale was the presentation of a bound copy of a special issue of the *Yale Journal of Biology and Medicine,* dedicated to Dr. Fulton. A silver medal inscribed "Physiologist, Teacher, Humanist, John Farquhar Fulton, to celebrate 25 years at Yale as Sterling Professor of Physiology and the History of Medicine, 1930-1955, From his Friends" was also presented to him.

His former pupils and friends came from as far away as Los Angeles and Seattle to honor Dr. Fulton, whose pioneer work in neurophysiology during the 1920's and 1930's outlined the basic concepts of the workings of the brain and led to the development of the frontal lobotomy procedure.

Dr. Fulton has combined a career of scientist, teacher, and writer. His biography of Dr. Harvey Cushing was published in 1946, and he is the author of studies on other leading figures in science and medicine.

Chester Jones, '19, was awarded the Rogerson Cup and medal for outstanding service to Williams College and for distinction in his field of endeavor at a homecoming luncheon at Williams. Dr. Jones, a member of the Class of 1913 at Williams, is chairman of the American Board of Internal Medicine, and a member of the staff of the Massachusetts General Hospital. He is a clinical professor of medicine in Harvard University.



Dr. Gross

On February 9, the Roswell Park memorial medal for "outstanding surgical achievement" was awarded to Robert E. Gross, '31, by the Buffalo Surgical Society. Dr. Gross is surgeon-in-chief of the Children's Hospital, Boston, and William E. Ladd Professor of Child Surgery in Harvard.

The Roswell Park medal was established nine years ago in memory of the late Dr. Park, nationally known surgeon and civic leader in Buffalo.

* * *

Dr. Ernest Knobil, associate in physiology at Harvard Medical School, has received a John and Mary Markle Foundation Fellowship Award for 1956. He is the fourth Harvard Medical School faculty member to have received a Markle award since 1947.



Dr. Jones and Dr. Baxter, President of Williams College

Working in collaboration with Dr. Roy O. Greep, professor of anatomy and Dean of the Faculty of the Harvard School of Dental Medicine, Dr. Knobil has focused a major part of his research on the question of growth processes in the primates.



William Tobey

Dr. Knobil

BOOK REVIEWS

BAKAY, LOUIS: The Blood Brain Barrier. Charles C. Thomas, Springfield, Illinois, 1955. 134 pages.

This 134 page book, which was published as one of the American Lecture Series by Charles C. Thomas, is chiefly a summary of the author's extensive experimental work with radioactive phosphorous (P^{32}) in the central nervous system. The book can be roughly divided into three parts: 1) a review of selected articles on the blood-brain-barrier problem; 2) experimental studies on the exchange of P^{32} in the normal developing nervous system of animals and man; and 3) the effect of noxious agents on the blood-brain-barrier and the isotope exchange in pathological processes of the central nervous system.

In his historical review he has culled most of the important papers from a prohibitively large literature. He considers various theories of the past regarding the blood-brain-barrier, but there is no serious attempt to synthesize the past work, recent studies, and new knowledge from other branches of physiology and biochemistry into a working hypothesis. The failure to do this makes his experimental reasoning often difficult to follow. One is given the impression that he feels the blood-brain-barrier is a uniform system treating all things alike in a manner which can be measured for all things with P^{32}.

His experiments, generally speaking, are studies on the appearance of P^{32} in the brain after intracisternal or intravenous injection. He used radioautographic pictures and tissue counting to localize the P^{32} in the brain. The tissue studies are recorded sometimes as counts per milligram of tissue and sometimes as specific activity. In calculating the specific activity he compares the total phosphorous of the brain to the diffusible phosphate of the plasma and CSF. No attempt is made to study various organic fractions except in some of the intracisternal experiments.

In addition to his P^{32} experiments he includes some vital dye experiments carried out with several different dyes.

His conclusion that a blood-brain-barrier exists for phosphate ions is based on the observed rate of penetration of P^{32} into the brain after intravenous injection and after intracisternal injection. He does not make clear his evidence for assuming he has produced equivalent conditions in his experiments with intracisternal and intravenous injection of P^{32}, and because of this, there are many who will feel he has not proven his point as to the existence of a phosphorous blood-brain-barrier. As most of the discussion and later interpretation of experiments depends upon this point, it is a serious defect of omission.

Considerable space is devoted to the consideration of those areas where the blood-brain P^{32} exchange is extremely rapid, namely the hypophysis, hypothalamus, pineal gland, area postrema and the choroid plexus.

The exchange of P^{32} in the fetus was studied by injecting the pregnant female and the sacrificing at intervals during pregnancy to determine the amount of P^{32} picked up by the fetus.

In the chapters on P^{32} exchange in pathological conditions he reports experiments with trauma to animal brains, and studies in patients with vascular lesions and tumors. These studies show a more rapid P^{32} exchange in the area of damage or pathological process than in the normal brain.

There is very little attempt to describe or synthesize the mechanism of the blood-brain-barrier phenomenon in either the experimental or pathological states. The similarity between the phosphorous exchange experiments and vital dye studies is considered, but there is no attempt to relate these with other isotope studies except in the case of some pathological conditions.

In spite of its conceptual shortcomings

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ORAL *Metrazol*

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and only superficial treatment of P^{32} exchange mechanisms and the metabolic processes of the brain, this book contains a wealth of data which represents a tremendous amount of careful work. Any serious student of brain metabolism and its related problems of barrier phenomena and cerebrospinal fluid formation will be rewarded by a careful study of this book.

Edgar A. Bering, Jr., '41

Merrill, John P.: The Treatment of Renal Failure. Therapeutic Principles and the Management of Acute and Chronic Uremia. Grune and Stratton, New York, 1955. 212 pages.

Dr. Merrill's extensive experience in this complicated field is summarized in a lucid monograph which effortlessly constructs a pyramid, based upon renal and body fluid physiology, which ascends to a point from which the reader can survey horizons which include "What to do," "What not to do," and "When to do nothing." The author carefully presents hypotheses which seem well established and afford better understanding of helpful therapeutic principles. Equally valuable is a critical review of therapeutic measures frequently recommended, but which the author believes without value. There are 11 quite short chapters which present current hypotheses about the excretion of salt and water, the concept of renal function and clearance tests and description of the anatomy and regulatory processes controlling the composition of body fluids.

The diseased kidney is described from a physiologic vantage point which emphasizes the concept of "decreased flexibility": in severe or advanced renal disease, functional impairment frequently can not be categorized in terms of specific anatomical localization, and renal failure is characterized by inability to compensate with marked narrowing of the limits of renal adjustment. Adjustments to stresses such as the excretion of water or acid-salt loads do occur, but rate and extent (adequacy) of adjustment are limited in the abnormal kidney. The physiologic defect and resulting inability to conserve fixed cation characterizing the polyuric phase of acute renal insufficiency is discussed. The role of diminished nephron function in response to filtered water and solute in the production of such paradoxes as excretion of concentrated urine by the uremic patient is discussed. One chapter deals with a physiologic intrepretation of the signs and symptoms of renal failure.

The largest portion of the monograph is devoted to theoretical and very practical aspects of management of acute and chronic renal failure by conservative medical methods which employ, to their fullest, the current concepts of body metabolism. Only a few pages are devoted to treatment of renal failure by extrarenal routes including intestinal lavage, peritoneal lavage, replacement transfusion, the artificial kidney and transplantation of the human kidney. The contribution of Dr. Merrill and associates in the latter two areas have been reported elsewhere and these chapters provide an excellent summary of their experiences. In order to consolidate the information given in the preceding chapters and demonstrate specific application, an illustrative case demonstrating the management of dehydration with incipient renal failure is given.

The monograph is highly recommended reading for those with a general interest in the subject and will undoubtedly fulfill its purpose as a guide to therapy and stimulus to thought for those working in this particular field. Two hundred and twelve pages including appendix, 31 figures and 12 tables, 4 additional tables indicating the compositions of irrigating fluids for extracorporeal dialysis and electrolyte, carbohydrate protein and fat composition of commonly used hospital liquids or food are presented.

Jack Metcoff, M.D.

THE HANS ZINSSER MEMORIAL FUND

Establishment of the Hans Zinsser Memorial Fund of the Harvard University School of Public Health is being undertaken by friends, colleagues and students of the late Hans Zinsser, M.D. (1878-1940). Noted as a teacher, research scientist and author, Dr. Zinsser was a Harvard faculty member from 1921 until his death in 1940. The purpose of the fund in his memory is "support for promising young scientists, support of field or laboratory projects and awards for outstanding achievement by students and research workers in the health field." The group of sponsors noted particularly that since Dr. Zinsser's interests were wide-ranging, and since his investigations encompassed both laboratory and field work including teaching as well as research, the scope of the fund should be broad enough "to include any disease or condition which may from time to time constitute a recognized peril to human health."

When the fund is activated, it will be administered by the Dean of the Faculty of Public Health. He will receive applications and proposals for use of the income and will recommend to the President and Fellows of Harvard College how it shall be allocated.

The sponsors of the Fund are Stanhope Bayne-Jones, John F. Enders, Jerome D. Greene, Mabel S. Ingalls, Rosanna Thorndike Leviseur, George Cheever Shattuck, Edward A. Weeks, Jr., Julia T. Weld, and Edwin B. Wilson.

Contributions to the Hans Zinsser Memorial Fund may be sent to The Secretary, Harvard School of Public Health, 55 Shattuck Street, Boston 15, Massachusetts. Checks should be made payable to Harvard University.

REGIONAL ACTIVITIES

NEW YORK

The Harvard Medical Society of New York met on Tuesday, April 3, 1956, for a reception and dinner beginning at 6:30 in the evening. As is customary, the affair took place at the Harvard Club.

The speaker of the evening was Bart J. Bok, Robert Wheeler Willson Professor of Astronomy in Harvard since 1947, and Co-Director of the Radio Astronomy Project, George R. Agassiz Station, Harvard University. Dr. Bok's illustrated lecture entitled "Radio Signals from the Milky Way" was enthusiastically received by a large audience.

S. CALIFORNIA

From Southern California comes the following note: "Doctors John Rock and Stewart Clifford were entertained at a dinner meeting at the California Club on February 15, 1956, at which 48 members of the Harvard Medical Alumni Association of Southern California were in attendance.

"Both Doctors Rock and Clifford brought to the society many interesting facts on developments at the Medical School. Many of the younger members were brought up to date and all enjoyed meeting the 'elder statesmen' again."

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THE COOP

Alumni Day

RAIN OR SHINE

THURSDAY, MAY 31, 1956

Registration — Begins at 9:00 a.m.
Building A, Harvard Medical School

Annual Business Meeting—the Alumni Association — 9:30 a.m.

Alumni Day Symposia — 10:00 - 12:00 noon
Amphitheatre D, Harvard Medical School

John P. Hubbard
President, Class of 1931
George Packer Berry
Dean, Harvard Medical School
Nathan M. Pusey
President, the University
— 12:00 - 12:30 p.m.

Buffet Luncheon — 12:30 p.m.
The Quadrangle, Harvard Medical School *(All Alumni are guests of the Association)*

SPEAKERS at the SYMPOSIA

Alan Gregg—*Vice President, The Rockefeller Foundation*
OPENING REMARKS

A. Baird Hastings—*Hamilton Kuhn Professor of Biological Chemistry*
"ATOMS IN THE MEDICAL SCHOOL"

A. Clifford Barger—*Associate Professor of Physiology*
"SOME OBSERVATIONS ON EXPERIMENTAL CHRONIC CONGESTIVE HEART FAILURE"

Richard Warren—*Associate Clinical Professor of Surgery*
"THE SURGEON CHISELS AT OLD AGE"

Paul D. White—*Member of the Board of Consultation, Massachusetts General Hospital*
SUBJECT TO BE ANNOUNCED

John P. Merrill—*Associate in Medicine* and Joseph Murray—*Instructor in Surgery*
"HOMOTRANSPLANTATION OF THE KIDNEY"

ALUMNI DAY COMMITTEE

Eugene C. Eppinger, *Chairman*
George P. Berry
Thomas H. Lanman
J. Englebert Dunphy, *Moderator*

Class Day

Friday, June 1, 1956

Class Day Exercises for the Class of 1956 — The Quadrangle 10:30 a.m.
A feature of the Exercises will be the presentation of the Alumni Prize

Class Day Luncheon — The Quadrangle 12:00 noon
(All Alumni are guests of the School)